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In The

Supreme Court of the United States

October Term, 1994

AUTO-OWNERS INSURANCE COMPANY,

Petitioner,

vs.

THORN APPLE VALLEY, INC.,

Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Where a coordination of benefits clause in a private contract of insurance comes into conflict with an opposing coordination of benefits clause contained in an employee benefit plan, does the federal common law under ERISA resolve the impasse by "preempting" (invalidating) the private insurer's clause, such that the ERISA plan's clause is given full force and effect (rendering its coverage secondary to the insurer's); or does the federal common law resolve the impasse by according equal validity to the competing clauses, recognizing them as mutually exclusive, and dictating that primary responsibility for the mutually covered loss is shared equally between the two coverage providers?

PARTIES TO THE PROCEEDING AND RULE 29.1 STATEMENT

Auto-Owners Insurance Company brought this action as plaintiff against Defendant, Thorn Apple Valley, Inc., Respondent herein. Chris L. Shattuck was also named as a defendant in the original state court complaint, but solely as an interested party as the individual whose benefits are the subject of this priority of coverage dispute. He did not participate or appear in any stage of this litigation.

Petitioner, Auto-Owners Insurance Company, is not a subsidiary of any parent corporation, and has no subsidiary companies that are not wholly-owned.

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No.

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PETITION FOR A WRIT OF CERTIORARI

Auto-Owners Insurance Company respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 3a-11a) is reported. *Auto-Owners Insurance Company v. Thorn Apple Valley, Inc.*, 31 F.3d 371 (6th Cir. 1994). The opinion of the district court (App., *infra*, 14a-25a) is also reported. *Auto-Owners Insurance Company v. Thorn Apple Valley*, 818 F. Supp. 1078 (W.D. Mich. 1993).

STATEMENT OF JURISDICTION

The judgment of the court of appeals was entered on August 1, 1994, and was followed by a timely filed motion for rehearing and petition for rehearing en banc (*see* Sixth Circuit Local Rule 14(a)). The motion for rehearing was denied by order of September 26, 1994, and a petition for writ of certiorari is due on December 25, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This matter arises under the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* Because no provision in ERISA addresses the specific question presented, this case involves the federal common law under ERISA. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). *See D'Oench, Duhme & Co., Inc., v. Federal Deposit Insurance Corporation*, 315 U.S. 447, 465-475 (1942) (Jackson, J., concurring).

The court of appeals based its decision on "the preemptive effect of ERISA" (App., *infra*, 10a). The preemption provision, § 514 of ERISA, 29 U.S.C. § 1144, provides in pertinent part:

> **§ 1144. OTHER LAWS**
>
> (a) *Supersedure; effective date*
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any

employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and application*

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

STATEMENT OF THE CASE

A. Factual Background

The facts which give rise to the legal question presented are not in dispute. On June 18, 1989, Chris Shattuck was injured in an

automobile accident and as a result incurred extensive medical expenses. He was covered as an insured under his father's no-fault automobile insurance policy issued by Petitioner, Auto-Owners Insurance Company (Court of Appeals Appendix ["C.A. App."], 5, ¶6; *id.*, at 14, n. 1). The automobile policy included coverage for personal injury protection benefits (medical expenses), but only "to the extent that same are in excess of coverage for expenses provided under any individual or group health care coverage plan", such as the coverage provided by the employee benefit plan of Respondent, Thorn Apple Valley, Inc. (*id.*).

Shattuck also was covered under his father's participation in Respondent's ERISA-qualified employee benefit plan (C.A. App., 14). As such, he enjoyed comprehensive, primary health coverage, except that the plan also contained a coordination clause, as follows:

> COORDINATION OF BENEFITS
>
> In addition to the benefits payable under this Plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under Group Fault or No-Fault Auto Insurance, Individual No-Fault Auto Insurance, Motorcycle Insurance, Medicare or another group plan. Should this type of duplication occur, the insurance does not apply to any liability for losses covered by a primary contributory, excess, secondary or any other coverage of any other basis by any other insurance company, under any other types of circumstances, particularly such benefits as may be payable under any type of coordinating policy with an automobile

> insurance carrier for first party benefits under MCLA 500.3109, et seq.

(C.A. App., 26).[1]

At the time of his accident, then, Chris Shattuck was covered by a no-fault insurance policy whose personal injury protection coverage was expressly secondary to any general health coverage plan, and was also covered by Respondent's comprehensive health coverage plan which was expressly coordinated with any benefits "as may be payable" under any Michigan no-fault insurance coverage.

After the accident, claims for medical expense benefits were submitted both to Petitioner and Respondent. Respondent, relying upon its coordination of benefits clause, denied payment. Petitioner, in order to ensure that Shattuck's expenses did not remain unpaid, made full payment of all outstanding expenses and brought this declaratory action to recoup the monies it had paid and seeking a declaration with regard to the parties' responsibilities for future expenses.

B. Proceedings Below

On August 12, 1992, Petitioner filed this case in the

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1. Quoting the Thorn Apple Valley coordination of benefits clause, the court of appeals stated:

> As this language makes clear, the TAV plan was in direct conflict with the Auto Owners policy with respect to coordination of benefits; both the plan and the policy purported to make the other primarily liable for payment of medical expenses.

(App., *infra*, 5a).

Michigan Circuit Court for Ionia County seeking declaratory relief and reimbursement for the medical expenses it had paid. Asserting federal question jurisdiction, Respondent removed the case to the United States District Court for the Western District of Michigan. 28 U.S.C. § 1331; *see Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987).

In lieu of responsive pleadings, Respondent filed a motion to dismiss and/or for summary judgment based upon its contention that any relief under state law was preempted by ERISA, and ERISA itself provided no relief for Petitioner. In its responsive brief, Petitioner cross-moved for summary judgment in its favor, asserting that the federal common law of ERISA provided the relief sought.

The district court denied Respondent's motion and granted summary judgment in favor of Petitioner (App., *infra*, 14a-26a). In its opinion of April 12, 1993, the court first held that the solution to this coverage priority dispute under Michigan law[2] was inapplicable due to ERISA preemption (*id.*, at 18a-19a), a point conceded by Petitioner in light of *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), *Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 592-593 (6th Cir. 1992), and *Lincoln*

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2. In Michigan, no-fault automobile insurers are statutorily required to "offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured." Mich. Comp. Laws § 500.3109a; Mich. Stat. Ann. § 24.13109(1). In order to effectuate this mandated reduction in premiums, the Michigan Supreme Court held in *Federal Kemper Ins. Assoc. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W. 2d 590 (1986), that primary liability falls on the health insurer when a conflict exists between the COB clauses of a no-fault insurance policy and another provider of health and accident coverage. *See Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 590 n. 3 (6th Cir. 1992); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc.*, 970 F.2d 206, 208 n. 2 (6th Cir. 1992).

Mutual Casualty Co. v. Lectron Products, Inc., 970 F.2d 206, 209-210 (6th Cir. 1992) (*id.*).

The court then proceeded to reject Respondent's position that a finding of ERISA preemption puts an end to the inquiry. Following the Sixth Circuit's suggestion in *Auto Club Ins. Assoc.*, 961 F.2d at 594-595 and *Lincoln Mutual*, 970 F.2d at 211, the district court applied the Seventh Circuit's analysis and holding in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989). It recognized that both coverage providers in this case purported to be secondary due to the presence of the other, and that "the ERISA statute itself does not provide an answer." The district court thus looked to prevailing state law methods for resolving priority of coverage conflicts, and held as a matter of federal common law that the primary liability for Shattuck's medical expenses must be shared equally between the two parties (App., *infra*, 19a-24a):

> Accordingly, this Court adopts the following rule as the appropriate coordination of benefits rule under ERISA: When there is a conflict between two unambiguous, valid, and irreconcilable "other insurance" or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis.

(App., *infra*, 24a).

The court of appeals reversed (App., *infra*, 3a-11a). Initially, the court rejected Respondent's principal contention (Appellant's Brief to the Court of Appeals, pp. 9-17) that the

absence of an express or implied statutory cause of action in ERISA foreclosed any jurisdictional basis for Petitioner's claim, finding such a basis in federal common law (App., *infra*, 7a-8a) (citing, *Kentucky Laborers Health & Welfare Fund v. Hope*, 861 F.2d 1003, 1005 (6th Cir. 1988), and *Whitworth Bros. Storage Co. v. Central States Fund*, 794 F.2d 221 (6th Cir.), *cert. denied*, 479 U.S. 1007 (1986). Furthermore, the court noted that, while the Michigan law that would have resolved the priority of coverage conflict in favor of the no-fault insurer was preempted, such preemption " 'does not, we reiterate, render the [no-fault insurer's] coordination of benefits clause *ipso facto* void.' " (App., *infra*, 9a, quoting *Auto Club*, 961 F.2d at 593).

The court nevertheless proceeded to hold that the ERISA plan's coordination of benefits clause must prevail, effectively rendering void the opposing clause in the private insurance contract (App., *infra*, 7a — "we conclude that when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan, including its COB clause, must be given full effect"). The brief statement of federal policy given in support of its decision was ERISA's purpose of protecting the interests of plan participants and beneficiaries (*id.*, at 10a): "In our view, this directive means that Congress sought to guard qualified benefit plans from claims . . . which have been expressly disavowed by the plans."

The court concluded by determining that private insurers and ERISA benefit plans do not litigate on a level "playing field" (*id.*, at 10a). Explicitly rejecting the contrary decision of the Seventh Circuit in *Winstead*, the court of appeals posited that the two coordination of benefits clauses do not compete equally because the COB clause in the plan "is bolstered by the preemptive effect of ERISA."

REASONS FOR GRANTING THE WRIT

This case presents an important and recurring question of federal law under ERISA. As coverage providers of all types endeavor to minimize costs and prevent payment of needlessly duplicative benefits, disputes over conflicting coordination of benefits clauses between private insurers and ERISA-qualified plans are increasingly common. Because the ERISA statute itself provides no coordination of benefits rule, an appropriate *and uniform* rule of federal common law is needed. As the Fourth Circuit recently observed, the "federal common law [of ERISA] should be consistent across the circuits. To the extent that inconsistencies arise, Congress and the Supreme Court are capable of harmonizing them." *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1453 (4th Cir. 1992). The degree of inconsistency among the courts being faced with these disputes now requires Supreme Court review.

The decision of the court of appeals is also fundamentally flawed. First, the court extended the notion of "ERISA preemption" beyond displacement of state *law* to the point of giving preemptive force to plan provisions themselves such that perfectly valid *clauses* in private insurance *contracts* are "preempted." Second, while the court purported to be protecting the interests of plan participants and their beneficiaries (App., *infra*, 7a), in fact the court protected only the plan *itself* by insulating it from a claim where coverage exists. The holding is inimical to the interests of covered participants and beneficiaries.

I.

DESPITE THE NEED FOR UNIFORMITY OF FEDERAL ERISA LAW, THE COURT OF APPEALS' HOLDING IN THIS CASE IS INCONSISTENT WITH PREVIOUS DECISIONS OF THE SIXTH CIRCUIT AND IN DIRECT CONFLICT WITH DECISIONS OF THE SEVENTH CIRCUIT AND OTHER JURISDICTIONS.

This case raises the question of how to reconcile priority of coverage disputes where both parties would provide primary coverage of the loss but for their mutually exclusive coordination of benefits clauses. Expressly rejecting the holding of the Seventh Circuit in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989), and despite its own recent precedent establishing that ERISA preemption does not render a private insurer's COB clause void (*Auto Club*, 961 F.2d at 593; *Lincoln Mutual*, 970 F.2d at 211), the court of appeals below held that the coordination of benefits (COB) clause of a qualified ERISA plan is to be given full effect, to the detriment of a private insurer whose coverage is subject to an equally valid coordination of benefits clause.

The *Winstead* court had addressed virtually the same set of facts, except that it was the ERISA plan that initially paid the accident victim's medical costs and then sought reimbursement from the automobile insurer. Both carriers had COB provisions to the effect that any other coverage would be primarily liable for the expenses. The automobile insurer claimed that Michigan's special rule announced in *Federal Kemper Ins. Co. v. Health Ins. Admin.*, 424 Mich. 537; 383 N.W.2d 590 (1986)[3], should apply to render the Fund's coverage primary. In response, the Fund argued not only that the *Federal Kemper* rule could not be imposed upon

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3. *See* n. 2, *supra*.

an ERISA plan, but that "federal ERISA law preempts the Indiana Insurance *policy.*" It argued that, to the extent that the insurer's provisions conflicted with its own of coverage, "the terms and condition of the Fund policy must be enforced." *Winstead*, 855 F.2d at 433 (emphasis added).

The Seventh Circuit rejected the plan's notion of ERISA preemption. While agreeing that application of Michigan's *Federal Kemper* rule was preempted[4], it could not accept the suggestion that a provision in the accident victim's insurance contract was encompassed within the scope of ERISA preemption and thereby rendered unenforceable. Instead, the court accorded equal validity to the parties' competing COB clauses, found them to be mutually repugnant and, guided by rules traditionally applied in contract interpretation for reconciling COB clauses, established the federal common law rule that both carriers would share primary responsibility on a pro rata basis. 855 F.2d at 433-434.

The Supreme Court of Kansas likewise has rejected the argument that the COB clause of an ERISA benefit plan must prevail over the competing COB clause of a private insurer's contract. In *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 237 Kan. 829, 703 P.2d 1384 (1985), a private

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4. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), this Court broadly construed the preemption provisions of ERISA to hold that qualified plans could not be subject to state laws that regulate insurance, effectively overruling *Northern Group Services, Inc., v. Auto-Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). *See Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d at 592-593. In *Winstead*, the Seventh Circuit did not apply the *Northern Group Services* analysis. Thus, although it pre-dated *FMC*, *Winstead* is entirely consistent with and in fact foreshadowed the state of the law post-*FMC*. *See Auto Club*, 961 F.2d at 595 n. 14. Respondent has conceded that the case at bar is "essentially identical" to *Winstead* (Appellant's Brief to the Court of Appeals, p. 2).

insurer paid benefits then sought reimbursement from an employee benefit plan. The court examined the language of the competing COB clauses and, applying traditional methods for discerning the intent of the respective coverage providers[5], held

5. Courts generally follow one of two approaches to resolve the conflict that arises when two coordinated coverages clash over a given loss. The so-called "majority rule" requires the court to examine the competing clauses to discern the intent of the respective coverage providers based on whether they utilized "escape", "excess" or "pro rata" coordination language, and attempt to reconcile the apparent intentions. The so-called "minority rule" posits that such analysis ultimately is circular, dependent on which policy is read first. Under the minority approach, opposing COB clauses are deemed to be mutually repugnant regardless of their specific types, and the loss is equally apportioned between the carriers to the extent of their duplicative coverage. Even under the "majority rule," however, the opposing clauses frequently are found to be irreconcilable with the result that primary responsibility is shared equally between the parties. *See St. Paul Fire & Marine Ins. Co. v. American Home Assur. Co.*, 444 Mich. 560, 565-577, 514 N.W.2d 113 (1994), and cases cited therein; *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 703 P.2d at 1388-91; *Starks v. Hospital Service Plan of N. J., Inc.*, 182 N.J. Super. 342; 440 A.2d 1353, 1359 (1981), *aff'd*, 91 N.J. 433, 453 A.2d 159 (1982). There is a "growing tendency" toward rejecting the "circular reasoning" of the majority rule. 16 *Couch on Insurance*, 2d, § 62:79, p. 550 (Lawyers Co-Op. 1983); *Auto Club*, 961 F.2d at 595 n. 13 (minority view now referred to as a " 'popular approach[ ]' ").

Because the Sixth Circuit appeared to endorse the so-called minority approach adopted in *Winstead* (*Auto Club*, at 594-595), and because of its practical simplicity, Petitioner has advocated only that approach in this case. **If the "majority rule" were applied, however, Respondent's coverage would be primary and Petitioner's only secondary.** Respondent's COB is an "escape" clause, such that the plan *normally* provides full, primary health coverage with the *exception* turning on whether there is coverage that is "payable" causing "duplication [to] occur" (Respondent's COB clause, quoted *supra*, at pp. 4-5). Petitioner's no-fault insurance policy, on the other hand, while providing collision, liability, and other such coverages, *normally* does not provide medical benefits (a reduced premium was paid just for this reason),

(Cont'd)

that the private insurer was secondary and the ERISA plan was primary. The defendant had "contend[ed], in essence, that by virtue of its plan being rooted in ERISA, it is placed in an unassailable position when challenged by a plan [private insurer] rooted in state law." 703 P.2d at 1388. The court rejected this notion: "The fact that the Riverside plan is rooted in ERISA is not, we believe, a significant factor in the determination of the issue before us. Therefore, the matter of preemption is not involved herein" (*id.*).

The Kansas Supreme Court stated that its holding was "consistent with the rationale expressed in *Northeast Dept. ILGWU v. Teamsters Local Union No. 229*, 764 F.2d 147 (3rd Cir. 1985)." 703 P.2d at 1390. In *ILGWU*, the Third Circuit addressed a conflict between one plan's escape clause and another plan's excess clause, the types of COB clauses present in the case at bar.[6] Determining that the competing clauses could not be harmonized by their respective intents ("each plan provides primary coverage unless the other plan provides primary coverage" — 764 F.2d at 161), the court looked to prevailing rules of state common law (*id.*, at 162-163) as an appropriate basis for federal common law under ERISA. Because escape clauses are disfavored and generally not enforced as against excess clauses, which are more compatible with the interests of the insured, the Third Circuit held: "escape clauses in ERISA covered employee benefit plans are unenforceable as a matter of law." *Id.*, at 164. Were this

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(Cont'd)
except on an "excess" basis. Primary coverage thus is not "payable" and there is no "duplication." 16 *Couch on Insurance*, 2d, §62:77, p. 543 ("Where one of the policies contains an excess insurance clause and the other contains a no-liability [escape] clause, the conflict has been resolved in the greatest number of cases by imposing liability on the insurer issuing the policy containing the no-liability clause").

6. *See supra*, n. 5.

holding applied to the case at bar, Respondent's escape clause would be unenforceable and Petitioner's excess COB clause would render the no-fault coverage secondary.[7]

This manifest *lack* of uniformity among ERISA coordination of benefits cases recently prompted the California Court of Appeals to throw up its hands and apply its own *state* law to an ERISA coverage dispute. In *Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 19 Cal. Rptr. 2d 782 (1993), *cert. denied*, __ U.S. __, 114 S. Ct. 881 (1994), the court noted that the Ninth Circuit had endorsed the "birthday rule" as an appropriate ERISA coordination rule in *PM Group Life Ins. Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992). The California court, however, refused to follow *PM Group Life* due in part to a factual distinction (divorced/non-divorced parents), but primarily due to the lack of a uniform rule:

> Reasoning from the broad preemption provision in ERISA, the *PM Group Life* court focused primarily on the need to adopt a *uniform* federal rule under ERISA[.]. . .
>
> These considerations are not persuasive here. First, *federal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter. PM Group Life* does not appear to have been

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7. The Third Circuit's holding was reached in the context of a dispute between two ERISA plans, but the court nowhere suggested that the holding was limited to such circumstances. *ILGWU*, 764 F.2d at 164. Again, Petitioner has not advocated avoidance of Respondent's COB clause, but rather the Seventh Circuit's *Winstead* rule that accords equal validity to the competing clauses. *See supra*, n. 5. *Also see Winstead*, 855 F.2d at 434, discussing *ILGWU*.

> aware of cases from the Sixth and Seventh Circuits which adopted an approach altogether different from the birthday rule. (See *Auto Club Ins. v. Health and Welfare Plans* (6th Cir.1992) 961 F.2d 588, 594-595; *Winstead v. Indiana Ins. Co.*, (7th Cir.1988) 855 F.2d 430, 433-434.

Inter Valley, 19 Cal. Rptr. 2d at 786 (emphasis added).

As the above indicates, the California court viewed the Sixth Circuit as already having endorsed *Winstead*'s equal apportionment of primary liability. In rejecting this common sense approach in favor of one which renders the COB clauses of private insurers inferior to those of ERISA plans, the court of appeals thus not only has thrown yet another "rule" into the mix, but has tacitly contravened its own previous holdings that "ERISA preemption" does *not* invalidate a private insurer's competing, irreconcilable COB clause. *Auto Club*, 961 F.2d at 592-593; *Lincoln Mutual*, 970 F.2d at 211.

ERISA was intended to provide a single, uniform body of federal law to govern disputes involving qualified employee welfare benefit plans. The conflict now existing among the circuits in their approaches to resolving ERISA coverage priority disputes frustrates this purpose. Further review is warranted.

II.

THE COURT OF APPEALS MISAPPLIED THE PRINCIPLE OF ERISA "PREEMPTION" TO THE TERMS OF A PLAN COB PROVISION, AND CREATED A RULE OF LAW SPECIFICALLY ADVERSE TO THE INTERESTS OF PLAN PARTICIPANTS AND BENEFICIARIES.

1. This case presents a dispute between two providers of medical expense coverage with valid COB clauses that create a logical impasse: both cannot be secondary. The dispute is controlled by ERISA, but ERISA itself contains no coordination of benefits rule. Contrary to the approach taken by the court of appeals, the solution to the problem is not found in blurry notions of "the preemptive effect of ERISA" but in federal common law fashioned after equitable solutions developed by the states. As Justice Brennan observed in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S.134, 157 n. 18 (1985) (Brennan, J., concurring) (quoting *Wayne Chemical, Inc. v. Columbia Agency Service Corp.*, 426 F. Supp. 316, 325 (N.D. Ind.), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977):

> "Where the courts are required themselves to fashion a federal rule of decision, the source of that law must be federal and uniform. Yet, state law where compatible with national policy may be resorted to and adopted as a federal rule of decision. . . . Here, of course, there is little federal law to which the court may turn for guidance. State regulation of insurance, pensions, and other such programs, however, provides a pre-existing source of experience and experiment in an area in which there is, as yet, only federal inexperience."

In *Chemung Canal Trust Company v. Sovran Bank/ Maryland*, 939 F.2d 12 (2d Cir. 1991), the Second Circuit recognized in ERISA a federal common law remedy of indemnity and contribution. The court emphasized that it was not creating a right from whole cloth. Rather, "[w]e are simply following the legislative directive to fashion, where congress has not spoken, a federal common law for ERISA by incorporating what has long been embedded in traditional trust law and equity jurisprudence." *Id.*, at 16. Pursuant to the same legislative directive, the rule announced in *Winstead* is indeed "in keeping with generally accepted notions derived from state common law [and is] eminently fair and equitable." 855 F.2d at 434.

Thus it is just and equitable that the coverage provider who steps forward and protects the interests of the covered individual should receive reimbursement from the co-primary coverage provider in accordance with and to the extent of the other's liability on an equal share basis. In rejecting the "fair and equitable" solution espoused by the Seventh Circuit in favor of a rule which relegates private insurance contracts to second class status, the court of appeals erred.

Congress did not intend to create a fully insulated legal world around ERISA benefit plans. *See Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825, 833 (1988). Rather, coverage conflicts between plans and other insurers should be resolved in accordance with well recognized principles that govern "the reciprocal rights and duties of several insurers who have covered the same event." *Pacific Indemnity Co. v. Fireman's Fund Insurance Co.*, 175 Cal. App. 3rd 1191, 1197; 223 Cal. Rptr. 312, 315 (1985). The California court described the coverage relationship as follows:

> "The reciprocal rights and duties of several insurers who have covered the same event do

> not arise out of contract, for their agreements are not with each other. . . Their respective obligations flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. As these principles do not stem from agreement between the insurers their application is not controlled by the language of their contracts with the respective policy holders." . . . [Quoting *Signal Companies, Inc. v. Harbor Ins. Co.*, 27 Cal.3d 359, 369; 165 Cal. Rptr. 799; 612 P.2d 889 (1980).]
>
> Thus, Signal once again reaffirms the well recognized principle that the rights and duties of several insurers who have covered the same event but have not contracted with each other with respect to it, are not the same to one another as they are to their respective insureds. They are, instead, governed by and "flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden."

175 Cal. App. 3rd at 1197-98; 223 Cal. Rptr. at 315. The *Winstead* court preserved and applied the "equitable principles" cited above, and the court of appeals even acknowledged in this case that the *Winstead* approach would be "eminently fair" *if* the "playing field" were level (App., *infra*, 10a). The court refused to accord equal legitimacy to the COB clause in the private insurance contract, however, on the basis that "the TAV clause is bolstered by the preemptive effect of ERISA" (*id.*). This reasoning is flawed.

Congress' intent in enacting the ERISA preemption

provisions (29 U.S.C. § 1144) was to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, such that they would not be faced with conflicting or inconsistent State and local regulation of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 64-65 (1990). This legislative purpose is fully met where, as here, a specific state law such as Michigan's *Federal Kemper* rule is held to be inapplicable to resolve a COB contest between a private insurer and an ERISA plan. Such was the holding of the district court in this case (App., *infra* at 19a), the Sixth Circuit in *Auto Club*, 961 F.2d at 592-593, and the Seventh Circuit in *Winstead*, 855 F.2d at 433.

There is no sound basis, however, for the Sixth Circuit's proposition that "the preemptive effect of ERISA" was intended to "bolster[]" and accord "preemptive" force to whatever coverage priority language appears in a plan when it comes into logical conflict with a perfectly valid coordination of benefits agreement negotiated between a private insurer and its insured.

As the *Winstead* court explained, ERISA preempts *state law*, but it does not void the provisions of private insurance contracts. The court stated:

> [T]he district court rejected the Fund's broad construction of ERISA preemption, explaining that by its own terms ERISA was designed only to supersede "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan." (Emphasis supplied.) . . . *We agree* with the conclusion of the district court that *the relevant provision of the Indiana Insurance policy is not rendered void merely as the result of Crampton's concurrent ERISA coverage.*

> The decision to purchase insurance coverage in addition to ERISA coverage featuring an "other insurance" clause is a decision which undoubtedly affects the Fund's potential liability for benefits payments and is, therefore, a decision that "relates to" an ERISA benefits plan. *Id. Crampton's decision to so proceed, however, was a private contractual matter between her and Indiana Insurance;* it was in no way compelled by state law. As the district court properly concluded, nothing in ERISA suggests that individuals are barred from acting as Crampton did in insuring themselves. In fact, the state's ability to facilitate such private choice has been held by the Supreme Court, albeit implicitly, *not* to be preempted by ERISA. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 756-58 [ ] (1985). . . . The choice to avail oneself of [a reduced premium, excess-only automobile insurance] policy is strictly a personal one, and thus a matter that ERISA did not intend to preempt.

Winstead, 855 F.2d at 433 (emphasis in original in part, supplied in part).

When the question is properly viewed as a pure issue of priority involving a *valid* COB clause in an ERISA plan and involving an equally *valid* COB clause in a private contract of insurance, and with full recognition that special state rules (such as *Federal Kemper*) are preempted, ERISA provides no basis for a holding that one COB clause is *more* valid than the other.

2. The court of appeals based its conclusion that the playing field is not level (App., *infra*, 10a) on 29 U.S.C. § 1001(b), which defines the purpose of ERISA as protecting "the interests of participants in employee benefit plans and their beneficiaries." The court translated this defined purpose into an obligation to guard the plans (not the beneficiaries) against claims. It erroneously invoked the talisman of "preemption" and deferred to the COB clause in the plan, holding essentially that the terms of the plan will themselves determine the outcome of any dispute involving other coverage contracts. However, as observed by the court in *Wahl v. Northern Telecom, Inc.*, 726 F. Supp. 235 (E.D. Wisc. 1989), this is contrary to the intent of Congress:

> Finding that a self-insured plan is automatically exempt from state insurance regulations, however, does not dictate, as the defendant Northern claims, that the terms of an employee benefit plan are dispositive of the outcome. By preempting state law without providing any federal statute to replace it, Congress intended either (1) to eliminate all regulation of non-core ERISA matters for self-insured plans or (2) to replace the state regulations with federal common law.
>
> * * *
>
> If a court holds that federal common law dictates that the [beneficiary's] rights are determined solely by the employee benefit plan, then it essentially is holding that there is no federal regulation of this area of the law. This outcome, however, does not appear to be what Congress intended. Nowhere in the

> legislative history of ERISA does it appear that Congress wanted to reduce the substantive rights of participants and beneficiaries by allowing self-insured plans to be unregulated. . . .

Id., at 240-241.

Beneficiaries of an "unregulated" plan do not have their interests protected. Further, under the court of appeals' decision, ERISA plan members who drive automobiles will be disadvantaged by a plan's unregulated determination that it will not cover medical expenses incurred in an automobile accident when there is other insurance.

Michigan drivers, like those in most states, are required to purchase automobile insurance for their vehicles if they are to be driven on public roads. Individuals have the option of purchasing policies with full, unqualified medical coverage, or for a substantially reduced premium, electing a policy that coordinates with the insured's general health coverage plan, provided their health coverage plan extends to automobile accident-related expenses. Most Michigan drivers that have other health coverage elect the less expensive excess-only policy.

In the name of "protect[ing] 'the interests of participants in employee benefit plans and their beneficiaries' " (App., *infra*, 10a), the court of appeals has deprived ERISA plan participants and beneficiaries of the right to elect the reduced-premium policy — ***even though their ERISA health plan covers automobile accident-related expenses.*** Respondent's plan members will now be forced to spend substantially more for full-coverage, *non*-coordinated insurance policies despite having comprehensive health coverage that extends to automobile accidents.

There is no dispute that Respondent's beneficiary, Chris Shattuck, enjoyed comprehensive health coverage under the plan and that, furthermore, this coverage extended to any medical expense incurred, whether automobile accident-related or not. The Court should contrast these facts with those in *Liberty Mutual Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989). In that case the insured's health and accident coverage, provided through an ERISA-qualified benefits plan, did *not* cover motor vehicle accidents. The plan contained a clear exclusion, unqualified by any availability of other insurance. Individuals with such limited ERISA plan coverage are compelled to purchase more expensive, full-coverage automobile policies because they have no other applicable coverage with which to coordinate. The situation is fundamentally different, however, where, as here, the individual's ERISA benefits plan *does* cover (does not exclude) motor vehicle accident-related expenses.

To be sure, the plans of this type contain coordination of benefits clauses, with the intent that duplication of payment will be avoided and that the plan members will in no event go uncovered (*see* plan COB clause, *supra* at pp. 4-5). Nevertheless, the distinction between *no* coverage (*Liberty Mutual*) and *coverage* (this case) remains, and is fundamental. The holding reached by the court of appeals erases this distinction, and unnecessarily restricts ERISA plan members' freedom of contract.

CONCLUSION

This matter is of paramount importance not only to ERISA plan members and automobile insurers, but to all types of private insurers whose insureds might also be entitled to benefits under an ERISA plan with coordinated coverage. The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT FILED SEPTEMBER 26, 1994

No. 93-1606

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ORDER

AUTO OWNERS INSURANCE COMPANY, A MICHIGAN INSURANCE CORPORATION,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant,

CHRIS L. SHATTUCK,

Defendant.

BEFORE: NORRIS and DAUGHTREY, Circuit Judges; and GILMORE,* District Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

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* Hon. Horace W. Gilmore, Senior United States District Judge for the Eastern District of Michigan, sitting by designation.

Appendix A

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT
s/ Leonard Green
Leonard Green, Clerk se

APPENDIX B — OPINION AND ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT FILED AUGUST 1, 1994

No. 93-1606

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

AUTO OWNERS INSURANCE COMPANY, a Michigan insurance corporation,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant.

ON APPEAL from the United States District Court for the Western District of Michigan

Decided and Filed August 1, 1994

Before: NORRIS and DAUGHTREY, Circuit Judges; and GILMORE, Senior District Judge.*

ALAN E. NORRIS, Circuit Judge. This narrowly focused appeal presents a question of federal common law that stems from a dispute between two insurers, one of which qualifies as an employee welfare benefit plan under the Employment

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* The Honorable Horace W. Gilmore, Senior United States District Judge for the Eastern District of Michigan, sitting by designation.

Appendix B

Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. At issue is the extent to which conflicting coordination of benefits ("COB") clauses affect the relative liability of the parties.

I.

Plaintiff, Auto Owners Insurance Company ("Auto Owners"), is a Michigan insurance carrier that issues no-fault automobile insurance policies as pat of its business. Michigan law regulates the terms of such policies. This statutory scheme contains the following provision:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section are subject to prior approval by the commissioner and apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

Mich. Comp. Laws Ann., § 500.3109a (West 1993). Pursuant to this section, Auto Owners issued a no-fault automobile insurance policy to Joseph Shattuck that included a coordination of benefits clause. This clause provided that Auto Owners, as the no-fault carrier, would be liable to Shattuck for personal injury benefits only to the extent that such benefits were not covered by any health insurance plan he might have.

Appendix B

At the time that his Auto Owners policy was in force, Mr. Shattuck also had health care coverage through his employer, defendant, Thorn Apply Valley, Inc. ("TAV"). Neither party disputes that TAV provided this coverage in the form of an ERISA employee welfare benefit plan, as defined at 29 U.S.C. § 1002(1). Like the Auto Owners policy, the TAV plan contained a coordination of benefits clause:

> In addition to benefits payable under this Plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under Group Fault or No-Fault Auto Insurance . . . or another group plan. Should this type of duplication occur, the insurance does not apply to any liability for losses covered by a primary contributory, excess, secondary or any other coverage of any other basis by any other insurance company, under any other types of circumstances, particularly such benefits as may be payable under any type of coordinating policy with an automobile insurance carrier for first party benefits under MCLA 500.3109 et seq.

As this language makes clear, the TAV plan was in direct conflict with the Auto Owners policy with respect to coordination of benefits; both the plan and the policy purported to make the other primarily liable for payment of medical expenses.

This potential conflict became reality when Joseph Shattuck's son, Chris, was injured in an automobile accident on June 18, 1989. Auto Owners paid his medical expenses. When

approached by Auto Owners for reimbursement, the TAV plan declined coverage based upon its COB clause.

As a result, Auto Owners filed a complaint for declaratory relief in Michigan state court, contending that the effect of M.C.L.A. § 500.3109a and the COB clause in its policy was to entitle it to "recoupment" from the TAV plan of the medical expenses paid to Chris Shattuck. TAV subsequently removed the cause to federal district court pursuant to 28 U.S.C. § 1331.

The district court disposed of the case after both parties had submitted motions for summary judgment. In a thoughtful opinion, after reviewing case law in the area and attempting to divine trends in our court, the district court concluded that: "When there is a conflict between two unambiguous, valid, and irreconcilable 'other insurance' or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis." *Auto Owners Ins Co. v. Thorn Apple Valley, Inc.*, 818 F. Supp. 1078, 1083 (W.D.Mich. 1993). Applying this rule, the court then apportioned to each party fifty percent of the liability for Chris Shattuck's medical expenses.

II.

The issue before us has generated a division of opinion from courts that have visited it. On the one hand, the Seventh Circuit has endorsed the pro rata approach advocated by the district court. *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989). On the other hand, the Michigan Supreme Court, anticipating the development of federal common law in this circuit, recently held that a no-fault

insurer could not seek payment from an ERISA plan despite a coordination of benefits clause that purported to make the no-fault insurer only secondarily liable for medical expenses. *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 443 Mich. 358,505 N.W.2d 820 (1993), *cert. denied,* 114 S. Ct. 1300 (1994). The district court did not have this opinion before it, as it was issued several months after the district court's ruling. Although this court has been confronted on at least two occasions with a fact pattern similar to the one now before us, the court has not previously reached the issue. *See Lincoln Mut. Casualty Co. v. Lectron Prods. Inc., Employee Health Benefit Plan,* 970 F.2d 206 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992).

For the reasons outlined below, we conclude that when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan, including its COB clause, must be given full effect.

A. Jurisdiction

Before reaching the merits of the case, we must first determine whether the district court had jurisdiction. Faced with a nearly identical fact pattern in *Auto Club,* this court found that jurisdiction was proper pursuant to 29 U.S.C. § 1132(a)(1)(B).[1] *Auto Club* at 590. As TAV points out, that section empowers a

1. That section reads as follows:

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(Cont'd)

select group of persons — participants or beneficiaries — to bring civil actions. Auto Owners falls into neither of these categories and the company concedes that ERISA contains no provision specifically according it the right to bring a cause of action.

Nonetheless, cases from this circuit have premised jurisdiction on federal common law when the ERISA preemption provision has effectively deprived a plaintiff of a state law claim. *See, e.g., Kentucky Laborers Dist. Council Health and Welfare Fund v. Hope,* 861 F.2d 1003, 1005 (6th Cir. 1988); *Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund,* 794 F.2d 221 (6th Cir.), *cert. denied,* 479 U.S. 1007 (1986). Accordingly, in this circuit, in cases such as this one, where the outcome rests upon the district court's construction of federal common law, jurisdiction is grounded upon 28 U.S.C. § 1331. *Whitworth* at 236.

B. Preemption

Neither party disputes that ERISA preempts M.C.L.A. § 500.3109a. *See Auto Club,* 961 F.2d at 593 (discussing *FMC Corp. v. Holliday,* 498 U.S. 52 (1990)). Thus, the reliance that

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(Cont'd)

> (1) by a participant or beneficiary —
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132 (1988).

plaintiff once placed upon the Michigan statutory scheme governing no-fault automobile insurance has been abandoned.

However, as the opinion in *Auto Club* noted, this consideration does not necessarily mean that the ERISA plan must prevail:

> There still exists here the issue of which of two apparently valid insurance policies containing what would appear to be irreconcilable "other insurance" clauses is liable for payment of [insured's] medical expenses. . . .
>
> . . . .
>
> . . . The fact that, after *FMC*, the Auto Club policy no longer has priority over the [ERISA] Fund plan by virtue of 500.3109a does not, we reiterate, render the Auto Club coordination of benefits clause *ipso facto* void.

Id. Because no federal statute addresses the resolution of the conflict between the COB clauses, application of federal common law is appropriate. *Lincoln Mutual*, 970 F.2d at 211.

C. The Common Law Rule

Since the Supreme Court's landmark *Erie Railroad* decision,[2] development of federal common law has been sharply

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2. *Erie Railroad Co. v. Tompkins*, 304 U.S. 64 (1938).

curtailed. In some contexts, however, it remains a viable source of authority. On occasion, Congress explicitly directs the federal courts to develop a body of common law to fill in the interstices of a statutory scheme in order to ensure national uniformity of application. ERISA presents just such a situation, where federal common law is expected to develop and address rights and obligations arising under the Act. *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56 (1987); *In re White Farm Equipment Co.,* 788 F.2d 1186, 1191 (6th Cir. 1986).

The underlying purpose of ERISA is to protect "the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b); *see also Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 113 (1989) (citing *Shaw v. Delta Airlines, Inc.,* 463 U.S. 85, 90 (1983)). In our view, this directive means that Congress sought to guard qualified benefit plans from claims, such as that advanced by Auto Owners, which have been expressly disavowed by the plans.

While we agree that both COB clauses at issue are facially valid, we cannot accept the Seventh Circuit's conclusion that a "solomonic apportionment of liability" is appropriate. *Winstead,* 855 F.2d at 434. Such a result may be, as *Winstead* suggests, "eminently fair," but it accords insufficient weight to the policy consideration behind the enactment of ERISA. Our situation is unlike the one where the competition is between COB clauses in nonqualifying private insurance policies. There, the playing field is level; here it is not, since the TAV clause is bolstered by the preemptive effect of ERISA.

Accordingly, we conclude that the terms of the TAV plan, including its coordination of benefits clause, must be given full effect in order to comply with a primary goal of ERISA, which is

to safeguard the financial integrity of qualified plans by shielding them from unanticipated claims.

III.

For the foregoing reasons, the judgment of the district court is **reversed** and this cause is **remanded** with instructions that judgment be entered in favor of defendant, Thorn Apple Valley, Inc.

Appendix B

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No: 93-1606

AUTO OWNERS INSURANCE COMPANY, a Michigan Insurance Corporation,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant.

Before: **Norris** and **Daughtrey,** Circuit Judges; and **Gilmore,** Senior District Judge.

JUDGMENT

ON APPEAL from the United States District Court for the Western District of Michigan at Grand Rapids.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

ON CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court is REVERSED and the cause is REMANDED with instructions that judgment be entered in favor of defendant, Thorn Apple Valley, Inc.

ENTERED BY ORDER OF THE COURT
s/ Leonard Green
Leonard Green, Clerk.

Appendix B

A True Copy.

Attest:

Deputy Clerk

Issued as Mandate: 11-04-94

COSTS: NONE

Filing Fee .....$
Printing .....$

Total .....$

APPENDIX C — OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION DATED APRIL 12, 1993

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

File No. 1:92-CV-583

HON. ROBERT HOLMES BELL

AUTO-OWNERS INSURANCE COMPANY,

Plaintiff,

v.

THORN APPLE VALLEY and CHRIS L. SHATTUCK,

Defendants.

OPINION

In this ERISA[1] case involving a sponsor of a self-funded employee welfare benefit plan and a Michigan no-fault insurer, two conflicting "other insurance" or coordination of benefits provisions are presented. The question—which appears to be one of first impression in this Circuit—is which party, under federal common law, is primarily liable for coverage of a car accident injury claim in such a case. Concluding that the primary liability

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1. The Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461.

must be shared on a *pro rata* basis by the insuring parties, the ERISA plan sponsor's motion for dismissal/summary judgment is DENIED and the no-fault insurer's cross-motion for summary judgment is GRANTED.

I.

A.

The facts are not in serious dispute. Chris Shattuck ("Shattuck"), a minor, was injured in a motor vehicle accident on June 18, 1989. His injuries required medical attention.

Shattuck had two insurers for his medical expenses: Auto-Owners Insurance Company ("Auto-Owners"), his father's Michigan no-fault insurance carrier; and his father's self-funded employee welfare benefit plan sponsored by Thorn Apple Valley ("Thorn Apple"). Both Auto-Owners' no-fault policy and Thorn Apple's ERISA plan contained an unambiguous, valid, and irreconcilable "other insurance" or a coordination of benefit provision, which effectively placed the other insurer primarily liable for expenses arising out of car accident injuries.

Auto-Owners initially paid the medical expenses related to Shattuck's injuries. Subsequently, Shattuck's father submitted claims for medical benefits related to Shattuck's injuries to Thorn Apple's ERISA plan.

Thorn Apple's ERISA plan denied Shattuck's father's claims. It relied on its coordination of benefits provision contained in its ERISA plan. This denial, in turn, caused Auto-Owners to commence this action.

Appendix C

B.

The complaint was first filed in the Ionia County Circuit Court in Michigan. It was then removed to this Court on August 24, 1992.

In the complaint, Auto-Owners seeks to "recoup" from Thorn Apple all amounts which Auto-Owners has paid for medical benefits on behalf of Shattuck. It also requests a declaration that Thorn Apple, not Auto-Owners, is primarily liable for any of Shattuck's future automobile accident related medical expenses. Auto-Owners alleges that under its required coordination of benefits provision in its no-fault policy, *see* Mich. Comp. Laws § 500.3109a, which is in conflict with Thorn Apple's ERISA plan's coordination of benefits provision, it is entitled to recoupment of past expenses from Thorn Apple and a declaration of secondary liability for Shattuck's future expenses. *See Federal Kemper Ins. Co. v. Health Ins. Administration, Inc.*, 424 Mich. 537 (1986).

In response, Thorn Apple moves for dismissal under Fed. R. Civ. P. 12(b)(6) and/or summary judgment under Rule 56. Auto-Owners opposes Thorn Apple's motion and requests entry of summary judgment in its favor instead.[2]

II.

Thorn Apple advances two principal arguments in support of its motion. First, Thorn Apple contends that Auto-Owners' state law no-fault claim is preempted by ERISA. Second, Thorn Apple

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2. This Court construes Auto-Owners's request as a cross-motion for summary judgment.

argues that once there is a finding of ERISA preemption, federal law provides no further remedy for Auto-Owners. In short, Thorn Apple's position is that the ERISA preemption analysis is the only required substantive inquiry to resolve this coverage dispute involving conflicting "other insurance" or coordination of benefits provisions.

Auto-Owners, on the other hand, suggests that the inquiry is so straightforward. While conceding—at oral argument—that ERISA preempts Michigan's no-fault statute, Auto-Owners asserts that the real analysis only begins once that preemption finding is made; that under the recent Sixth Circuit law, courts must fashion an appropriate rule under federal common law of ERISA after finding that federal law governs a coverage dispute involving competing "other insurance" or coordination of benefits provisions contained in an ERISA plan and a no-fault insurance policy. And in fashioning such a federal rule, Auto-Owners urges this Court to adopt an approach taken by another federal circuit.

A.

This Court's analysis must, of course, begin with the applicable standard of review. Because matters outside the pleadings have been considered in evaluating the parties' motions, this Court must treat the motions as ones for summary judgment, and apply the standard for summary judgment. *See* Fed. R. Civ. P. 12(b); *Friedman v. United States*, 927 F.2d 259, 261 (6th Cir. 1991).

Rule 56 provides the compass for evaluating summary judgment motions. It states that summary judgment is appropriate only if "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter

of law." Fed. R. Civ. P. 56; *Guarino v. Brookfield Township Trustees*, 980 F.2d 399, 403 (6th Cir. 1992).

After careful review, there appears to be no genuine issue as to any material fact in this case. Except for one additional ERISA plan document submitted by Thorn Apple in support of its motion, both parties rely on the same alleged facts in the complaint. And the parties' almost exclusive focus on the two legal questions, the applicability of ERISA preemption and the availability of federal common law rule, only confirms the belief that there are no triable issues of fact at hand.

B.

This Court must then turn to the legal questions. Although two legal questions were originally presented by the parties, only one requires extended discussion now.

(1).

The first question, whether Auto-Owners's state law no-fault claim of recoupment is preempted by ERISA, is all but settled. In its initial responsive brief[3] to Thorn Apple's motion, Auto-Owners implicitly acknowledges that its state law no-fault claim is preempted by ERISA. *See* Auto-Owners Memorandum of Law at 8. And at oral argument, Auto-Owners, in response to this Court's inquiry, expressly conceded that preemption. Finally, no mention is made of ERISA preemption in Auto Owners's supplemental brief. *See* Plaintiff's Response to Supplemental Brief in Support of Defendant's Motion to Dismiss and/or for Summary Judgment.

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3. The parties have filed supplemental briefs during the pendency of the instant motions.

Of course, even if Auto-Owners had not acquiesced on Thorn Apple's preemption argument, it would not have been successful. The prevailing Sixth Circuit law—consistent with the Supreme Court's teaching in *FMC Corp. v. Holliday*, __ U.S. __, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990)—holds that where, as here, state law—such as the Michigan No-Fault Insurance Act, Mich. Comp. Laws § 500.3100 *et seq.*—relates to an ERISA plan, the federal law of ERISA preempts that state law. *Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 209-210 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588, 592-93 (6th Cir. 1992). Therefore, Auto-Owners's no-fault claim based on Michigan law is no longer viable in light of ERISA preemption.

(2).

But that does not end the matter. Because ERISA preemption does not resolve the coverage dispute, but merely suggests that federal law, instead of state law, governs the dispute, *see Lincoln Mutual*, 970 F.2d at 210-11; *Slice v. Norway*, 978 F.2d 1045, 1046 (8th Cir. 1992), this Court must next turn to the second question: what federal law resolves the dispute here.

(i).

To begin, the ERISA statute itself does not provide an answer. Nothing in the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, addresses an "other insurance" or a coordination of benefits provision that may contain in an insurance policy. *Lincoln Mutual*, 970 F.2d at 211; *see also PM Group Life Ins. Co. v. Western Growers Assur. Trust*, 953 F.2d 543, 546 (9th Cir. 1992) (Kozinski, J.) (noting that ERISA does not provide a coordination of benefits provision to resolve conflicts between two ERISA plans). Accordingly, there is no

statutory ERISA rule that this Court can readily apply to resolve the dispute here.

In enacting the ERISA statute, however, Congress anticipated this sort of a problem. Its legislative history indicates that Congress foresaw occasions where there would be gaps left in the express provisions of ERISA, *see Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984), and in such occasions, Congress intended courts to fill the interstices by developing federal common law of ERISA. *See* 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)); *see also Kwatcher v. Massachusetts Serv. Employees Pension Fund*, 879 F.2d 957, 966 (1st Cir. 1989).

To be sure, the Sixth Circuit has heeded this legislative directive by repeatedly recognizing the need to develop federal common law to address various issues involving rights and obligations under an ERISA plan. *See, e.g., Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund*, 982 F.2d 1006 (6th Cir. 1993) (reviewing under federal common law whether a contractual limitation on refunds for contributions mistakenly made is unreasonable); *Flacche v. Sun Life Assur. Co.*, 958 F.2d 730 (6th Cir. 1992) (declining to review the definition of the term fiduciary under federal common law because the ERISA statute already expressly addresses the term); *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991) (reviewing the doctrine of equitable estoppel under the Circuit's established federal common law).

In fact, the Sixth Circuit has specifically recognized that federal common law of ERISA must be developed to address the

central question in this case, namely, what coverage priority rule should apply in a case where there are two competing "other insurance" or coordination of benefits provisions. *See Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 211 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588, 594-95 (6th Cir. 1992).[4]

(ii).

In formulating a federal common law rule for evaluating a coverage priority question, this Court may review state law approaches, particularly because "states generally having had much more experience in the area of insurance contract interpretation." *Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1084 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990); *see also Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302, 311 (7th Cir. 1992) (in making federal common law rules, it is "proper to turn to state law when creating such rules, . . . as long as such state law is consistent with the policies underlying the federal statute at issue").

Two principal state law approaches have emerged. The Michigan Supreme Court has distinguished them as majority and minority views in *Federal Kemper Ins. Co. v. Health Ins. Administration, Inc.*, 424 Mich. 537 (1986):

> The majority rule attempts to reconcile the competing provisions by discerning the parties' intent through an analysis of the clauses. Critics of this approach argue that it

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4. Despite this suggestion by the Sixth Circuit, it appears that no district court in this Circuit (or elsewhere) has yet developed a federal common law rule that is applicable here.

> is circular and that the decision as to which clause is primary depends on which policy is read first. Thus some courts deem the provisions "mutually repugnant" and reject both clauses. Courts adopting this minority view . . . hold that liability must be prorated.

Id. at 543 (citations omitted); *see, generally* 8A Appleman, *Insurance Law and Practice* §§ 4907.65-4909 (1981).

The Michigan Supreme Court has not endorsed either approach. Rather, the Michigan Supreme Court has staked a different position by formulating a special rule mandating that when a no-fault insurance policy and a health insurance policy contain conflicting coordinated benefits provisions, the health insurance carrier will be primarily liable for the insured's medical expenses resulting from injuries suffered in a motor vehicle accident. *Federal Kemper*, 424 Mich. at 551.

In reviewing which of the foregoing approaches might be suitable here, however, this Court does not have a clean slate. In *Auto Club Insurance Association v. Health and Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992), the Sixth Circuit, addressing similar circumstances as here, suggested an approach that a district court may consider. The Sixth Circuit indicated, without expressly mandating, that in developing federal common law to resolve a conflict in two coordination of benefits provisions, the district court should review the Seventh Circuit's decision in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989).[5]

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5. The Sixth Circuit repeated this suggestion by approvingly citing *Winstead* in a later decision addressing the same issue. *See Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 211 (6th Cir. 1992).

Appendix C

In *Winstead*, the Seventh Circuit was confronted with an ERISA plan and a non-ERISA automobile insurance policy governed by Michigan's no-fault insurance law.[6] Both the ERISA plan and the non-ERISA insurance policy contained a coordination of benefits provisions. In resolving the conflict between the two provisions to determine primary coverage liability, the Seventh Circuit endorsed the district court's ruling that, based on federal common law, the liability between the ERISA plan and the non-ERISA insurer should be apportioned on a *pro rata* basis. The Seventh Circuit further explained that:

> Application by the district court in this case of such a solomonic apportionment of liability is not only in keeping with generally accepted notions derived from state common law, [citing insurance law treatises], but seems eminently fair and equitable.

Winstead, 855 F.2d at 434.

After careful review, this Court agrees with the *Winstead* approach—which is the minority state law approach in apportioning liability—in resolving a conflict in "other insurance" or coordination of benefits provisions. Besides the reasons already stated by the Seventh Circuit, this *pro rata* approach, as a federal common law rule, is a simple one to apply. *See cf. Edelmann v. Chase Manhattan Bank N.A.*, 861 F.2d 1291,

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6. Although *Winstead* preceded the Supreme Court decisions in *FMC Corp. v. Holliday*, __ U.S. __, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990), and *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Sixth Circuit found that those Supreme Court decisions did not affect *Winstead*. *See Auto Club*, 961 F.2d at 595 n. 14. And this Court's research discloses no Seventh Circuit decision repudiating or criticizing *Winstead*.

1301 n. 63 (lst Cir. 1988) (Wisdom, J., sitting by designation) ("A simple rule promotes predictability, certainty, and uniformity from case to case."). And adopting this approach, of course, promotes national uniformity, since another federal court has previously done so. *See PM Group Life,* 953 F.2d at 548. Finally, the *pro rata* approach, which provides coverage under an ERISA plan, is consistent with the purpose of ERISA of "protecting the interests of Plan members and their beneficiaries." *Luby v. Teamsters Health, Welfare, & Pension Trust Funds,* 944 F.2d 1176, 1187 (3d Cir. 1991).

Accordingly, this Court adopts the following rule as the appropriate coordination of benefits rule under ERISA: When there is a conflict between two unambiguous, valid, and irreconcilable "other insurance" or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis.

(iii).

Applying the *pro rata* rule here, this Court finds that the primary liability for Shattuck's medical expenses, including the future expenses, related to the automobile accident must be shared on a *pro rata* basis (50 percent each) by Auto-Owners and Thorn Apple, the two insuring parties. Thorn Apple's argument to the contrary is therefore rejected.

(3).

Having so concluded, this Court turns to Thorn Apple's other arguments. Two are worthy of brief discussion: (1) Thorn Apple asserts that this Court need not address any of the issues in this

case for lack of exhaustion of internal administrative remedies; and (2) Thorn Apple claims that there is no "real" conflict between the two coordination of benefits provisions.

This Court disagrees with both contentions. First, the exhaustion requirement is applicable when a participant or a beneficiary of an ERISA plan is challenging the Plan's denial of a benefit claim. *See Baxter v. C.A. Muer Corp.*, 941 F. 2d 451, 453-54 (6th Cir. 1991). It is not applicable where, as here, declaratory judgment and recoupment action—not a claim for benefits under ERISA—is brought by a non-participant or a non-beneficiary of an ERISA plan.

Second, Thorn Apple's argument regarding the characterization of the two coordination of benefits provisions in question—an argument mentioned in passing—was heard, considered, and rejected by the Michigan Supreme Court in *Federal Kemper, See* 424 Mich. at 542-44; *see also Auto-Owners Insurance Co. v. Lacks Industries*, 156 Mich. App. 837, 839-40 (1986) (rejecting a similar argument on the basis of *Federal Kemper*). There is no need to further discuss what the Michigan Supreme Court has already carefully explained.

III.

For the reasons stated above, Thorn Apple Valley's motion for dismissal or summary judgment is DENIED and Auto-Owners Insurance Company's cross-motion for summary judgment is GRANTED. An order consistent with this opinion shall issue forthwith.

Dated: April 12, 1993

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

Appendix C

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

File No. 1:92-CV-583

HON. ROBERT HOLMES BELL

AUTO-OWNERS INSURANCE COMPANY,

Plaintiff,

v.

THORN APPLE VALLEY and CHRIS L. SHATTUCK,

Defendants.

ORDER

In accordance with the opinion entered this date;

Thorn Apple Valley's motion for dismissal or summary judgment is DENIED and Auto-Owners Insurance Company's cross-motion for summary judgment is GRANTED.

IT IS SO ORDERED.

Dated: April 12, 1993

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

(2)

Supreme Court, U.S.
FILED
JAN 24 1995
OFFICE OF THE CLERK

No. 94-1137

In The

Supreme Court of the United States

October Term, 1994

AUTO-OWNERS INSURANCE COMPANY,
Petitioner,

-vs-

THORN APPLE VALLEY, INC.,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

AND APPENDIX

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

I.

WHETHER FEDERAL COMMON LAW UNDER ERISA ALLOWS A FEDERAL DISTRICT COURT TO INFER A FEDERAL CAUSE OF ACTION AND A FEDERAL REMEDY TO RESOLVE A PRIORITY OF COVERAGE DISPUTE BETWEEN NO-FAULT AUTOMOBILE INSURANCE COVERAGE, WHICH IS GOVERNED ENTIRELY BY STATE LAW, AND COVERAGE UNDER A SELF-FUNDED WELFARE BENEFIT PLAN, WHICH IS GOVERNED BY ERISA, DESPITE THE FAILURE OF CONGRESS TO PROVIDE FOR SUCH CAUSE OF ACTION AND REMEDY EXPRESSLY IN SECTION 502 OF ERISA.

II.

WHETHER, ASSUMING A CAUSE OF ACTION AND REMEDIAL AUTHORITY ARE AUTHORIZED BY CONGRESS TO RESOLVE A PRIORITY OF COVERAGE DISPUTE BETWEEN A NO-FAULT INSURER AND SELF-FUNDED ERISA PLAN, FEDERAL COMMON LAW UNDER ERISA REQUIRES THE PRORATION OF LIABILITY BETWEEN THE TWO ENTITIES.

PARTIES TO THE PROCEEDINGS

The parties to the proceedings below are listed in the caption. Respondent, Thorn Apple Valley, Inc., has no parent companies, affiliated companies or nonwholly owned subsidiaries.

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No. 94-1137

In The

Supreme Court of the United States

October Term, 1994

AUTO-OWNERS INSURANCE COMPANY,
Petitioner,

-vs-

THORN APPLE VALLEY, INC.,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION

Respondent, Thorn Apple Valley, Inc., respectfully requests the Court to deny the petition for certiorari, which seeks review of the decision of the U.S. Court of Appeals for the Sixth Circuit reported at 31 F.3d 371 (6th Cir. 1994).

STATUTORY PROVISIONS

The decision by the Sixth Circuit below was based on that court's construction of Section 514 the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Additionally, resolution of the issues raised in the petition, assuming the Court chooses to consider them, requires consideration and interpretation of § 3109a of Michigan's no-fault insurance law, MICH. COMP. LAWS § 500.3109a (1993), and § 502 of ERISA, 29 U.S.C. § 1132.

The foregoing statutory provisions are repeated in their entirety herein in Appendix A-1–A-16.

STATEMENT OF THE CASE[1]

This case arises from a dispute over whether no-fault automobile insurance coverage, which is governed by Michigan law, or coverage under a self-funded ERISA plan, which is governed entirely by federal law, is required to pay the medical expenses incurred by Chris Shattuck on account of his 1989 automobile accident.

Petitioner, Auto Owners Insurance Co. (Auto Owners), is a Michigan no-fault automobile insurance company. It sold no-fault auto insurance coverage to Joseph Shattuck under which his son, Chris Shattuck, was insured in 1989.

Joseph Shattuck was also an hourly employee of Respondent, Thorn Apple Valley, Inc. (TAV). As a fringe benefit, TAV provided medical benefits to Mr. Shattuck for himself and for his eligible dependents pursuant to a self-funded ERISA welfare benefit plan, which was also in effect in 1989.

It is uncontroverted that Chris Shattuck's 1989 auto accident was covered under his father's no-fault insurance policy with Auto Owners. Auto Owners paid the resulting medical expenses in their entirety.

In 1992, Auto Owners sued TAV in a Michigan state court, contending that since Chris Shattuck was also a beneficiary under TAV's ERISA plan it could "recoup" from TAV all medical payments made on Chris Shattuck's behalf. Auto Owners asserted in its complaint that its no-fault insurance policy provided benefits "only to the extent that same are in excess of coverage for expenses provided under any individual or group health care cov-

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[1] **We are generally satisfied with the summary of facts set forth in the opinion of the Sixth Circuit below. This additional summary is provided only to clarify the posture of this litigation.**

erage plan" and that a right of "recoupment" from TAV existed pursuant to MICH. COMP. LAWS § 500.3109a (1993).[2] TAV's ERISA plan, however, also expressly provided that its coverage "does not apply to any liability for any losses covered by" any kind of insurance, including "any type of coordinating policy with an automobile insurance carrier." For this reason, TAV denied coverage for Chris Shattuck's medical expenses, and refused to pay anything to Auto Owners.

TAV removed this action from state court to the U.S. District Court for the Western District of Michigan seven days after the complaint was filed. Shortly thereafter, TAV moved for summary judgment on the ground that Auto Owners' state law "recoupment" claim was preempted by ERISA. Auto Owners responded by asserting that although state law was preempted it could still "recoup" its no fault payments from TAV under "federal common law," and submitted a cross-motion for summary judgment.

On April 12, 1993, the district court denied TAV's motion, granted Auto Owners' motion and ordered that liability for Chris Shattuck's 1989 medical expenses be "apportioned between the insurers [*sic*] on a pro rata basis," which the court went on to define as "50% each." 818 F. Supp. 1078 (W.D. Mich. 1993). The district court agreed with TAV that state law was preempted and that "the ERISA statute does not provide an answer" to the coverage dispute, but then attempted to formulate a "federal common law rule" based on the "minority state law approach" to apportioning liability between insurance companies.

The Sixth Circuit reversed the district court on August 1, 1994. 31 F.3d 371 (6th Cir. 1994). It reasoned

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[2] This statute in fact merely required Auto Owners to *offer* no-fault insurance coverage which purported to be secondary to other medical coverage on its insureds.

that the underlying purpose of ERISA — the protection of "the interests of participants in employee benefit plans and their beneficiaries" — would be best served by enforcing the ERISA plan's coordination of benefits provision as written. The court rejected the district court's apportionment of liability between Auto Owners and TAV, citing an analogous decision by the Michigan Supreme Court in *Auto Club Insurance Ass'n.* v. *Frederick & Herrud, Inc.*, 443 Mich. 358, 505 N.W.2d 820 (1993), *cert. denied sub nom., Auto Club Insurance Ass'n.* v. *Pentwater Wire Products, Inc.*, 511 U.S. ___, 114 S. Ct. 1300 (1994). The court concluded that the "preemptive effect of ERISA" warrants giving "full effect" to the TAV plan's coordination of benefits provision despite the presence of a similar provision in Auto Owners' no-fault auto insurance policy. 31 F.3d at 375.

Auto Owners filed a petition for rehearing, *en banc*. The Sixth Circuit denied this petition on September 26, 1994.

Auto Owners now urges this Court to consider and adopt a pro rata apportionment "federal common law" remedy for coverage disputes between Michigan no-fault auto carriers and ERISA plans.

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REASONS WHY THE PETITION SHOULD BE DENIED

Once this Term and once last Term the Court has declined to consider the same narrow and parochial question formulated by Petitioner here. *Auto Club Insurance Ass'n.* v. *Pentwater Wire Products, Inc.*, 511 U.S. ___, 114 S. Ct. 1300 (1994); *Auto Club Ins. Ass'n.* v. *White & White, Inc.*, 513 U.S. ___, 130 L. Ed. 2d 283 (1994). Auto Owners parrots the contentions made in support of these previous petitions, and urges nothing warranting a different result here.

I.

SINCE AUTO OWNERS HAS NO ERISA CAUSE OF ACTION AGAINST TAV TO BEGIN WITH, THERE IS NO NEED TO CONSIDER THE PARAMETERS OF FEDERAL COMMON LAW UNDER ERISA.

The parties in this litigation have not chosen quite as "narrow [a] battlefield" as Petitioner suggests, and certainly has not left only the abstractions formulated in the petition for possible consideration by this Court. *See generally Mertens* v. *Hewitt Associates*, 508 U.S. ___, 113 S. Ct. 2063, 2067 (1993). In fact, it is doubtful that a cause of action under ERISA even exists between Auto Owners and TAV under federal law, much less one which would necessitate an examination of the "federal common law" issue Petitioner has urged here and below. In order to reach the "federal common law" issue Auto Owners posits, a court must necessarily consider whether ERISA permitted Auto Owners to sue TAV for "recoupment" in the first place. Since maintenance of such a cause of action by Auto Owners cannot be squared with the language of ERISA or with previous decisions of this Court, review of the question of just

how "federal common law" might resolve such a non-existent claim is at best hypothetical.[3]

In *Mertens*, the Court reaffirmed that claims and remedies under ERISA are limited to those specifically set forth in the statute's "comprehensive and reticulated" civil enforcement provision. *See Mertens* v. *Hewitt Associates*, 508 U.S. ___, 113 S. Ct. 2063 (1993). In view of this "carefully crafted and detailed enforcement scheme," the Court stated its "unwillingness to infer causes of action in the ERISA context." 113 S. Ct. at 2067; *see also Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134, 146-47 (1985); *Pilot Life Insurance Co.* v *Dedeaux*, 481 U.S. 41, 54 (1987).[4] We are unaware of any change in the Court's approach since *Mertens*. *See Buckley Dement, Inc.* v. *Travelers Plan Administrators of Ill., Inc.*, 39 F.3d 784, 788-790 (7th Cir. 1994).

"Federal common law" offers no detour around ERISA's comprehensive civil enforcement scheme or the foregoing principles. True enough, the legislative history underlying ERISA indicates that Congress intended that a "body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29942 (1974) (remarks of Senator

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[3] The district court below candidly acknowledged that "the ERISA statute itself does not provide an answer" for this dispute. 818 F. Supp. at 1081. Although this did not deprive the district court of federal jurisdiction, it should arguably have compelled the prompt dismissal of Auto Owners' lawsuit then and there. *See generally Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987); *Amos* v. *Blue Cross & Blue Shield of Alabama*, 868 F.2d 430, 431 (11th Cir. 1989), *cert. denied*, 493 U.S. 855 (1989) (ERISA preemption is "not a gateway but a barrier to state law causes of action").

[4] The unwillingness of this Court to legislate new causes of action under statutes containing comprehensive enforcement and remedial provisions is not limited to ERISA litigation. *See also Northwest Airlines, Inc.* v. *Transport Workers Union of America*, 451 U.S. 77, 97 (1981) ("the judiciary may not in the face of such comprehensive legislative schemes, fashion new remedies that might upset carefully considered legislative programs").

Javits), *quoted in Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. at 56; *see also Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 110 (1989). But, "the authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute." *Mertens* v. *Hewitt Associates*, 508 U.S. at ___, 113 S. Ct. at 2070. *See also Buckley Dement, Inc.* v. *Travelers Plan Administrators of Ill., Inc.*, 39 F.3d at 789-790.

Auto Owners nonetheless urges a result which is directly at odds with this principle, and which invites this Court to engage in virtually unlimited judicial legislation. For only by first ignoring the text of ERISA and inventing judicially a cause of action that Congress did not authorize in the statute, would a court then have occasion to address the abstract question of what "federal common law" rule applies. In this regard, "recoupment," the ostensible basis for Auto Owners' claim against TAV, was not even a recognized claim at common law, *see, e.g., Frederick* v. *United States*, 386 F.2d 481, 487 (5th Cir. 1967) (recoupment is "for defensive use only, and a defendant [can] not use it as [a] basis for . . . judgment in his favor"), let alone is it among the six causes of action that were expressly enacted by Congress in Section 502 of ERISA. Nor is Auto Owners among those entities that are authorized by Congress to bring actions under Section 502.

Congress surely could have recognized a "recoupment" claim, or otherwise provided for "litigation when a plan subject to ERISA interlocks with coverage governed by state law," but it did not do so. *See Foster McGaw Hospital of Loyola University of Chicago* v. *Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, Local 786*, 925 F.2d 1023, 1025 (7th Cir. 1991), *cert. denied*, 502 U.S. ___, 112 S. Ct. 74 (1991). No conceivable justification exists for judicially revising Congress' statutory scheme and creating a cause of action for insurance companies that wish to sue ERISA plans under theories that were unknown even at common law!

Without a cause of action between Auto Owners and TAV in the first instance, the Court has no need to consider the question of how "federal common law" might resolve it.

II.

THERE IS NO CONFLICT WITHIN THE SIXTH CIRCUIT, AMONG THE CIRCUITS OR WITH OTHER JURISDICTIONS CONCERNING THE APPLICATION OF FEDERAL COMMON LAW TO COVERAGE DISPUTES BETWEEN ERISA PLANS AND INSURANCE COMPANIES.

There is no ongoing conflict within the Sixth Circuit, among the federal circuits, or between the Sixth Circuit and state jurisdictions warranting this Court's consideration of the issue posited in Auto Owners' petition. In fact, a review of the pertinent cases confirms that no-fault automobile insurance/ERISA plan coverage conflicts are peculiar to the state of Michigan, and that the law prevailing in the Sixth Circuit and in Michigan's state courts is consistent and uniform.

Sixth Circuit

Prior to its decision in this case; the Sixth Circuit had on a number of previous occasions addressed various issues arising in the context of Michigan no-fault auto insurance/ERISA plan coverage disputes, with a progression of outcomes and rationales. *See, e.g., Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied, Northern Group Services, Inc.* v. *State Farm Mutual Automobile Insurance Co.*, 486 U.S. 1017 (1988); *Liberty Mutual Insurance Group* v. *Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989); *Auto Club Insurance Ass'n.* v. *Health & Welfare Plans, Inc.*, 964 F.2d 588 (6th Cir. 1992); *Lincoln Mutual Casualty Co.* v. *Lectron Products, Inc. Employee*

Health Benefit Plan, 970 F.2d 206 (6th Cir. 1992). The Sixth Circuit's decision below in this case was the next logical step in this progression. In the context in which it was decided, it is entirely consistent with previous decisions.

In *Northern Group Services*, the Sixth Circuit in 1987 concluded that ERISA did not preempt the application of Michigan's no-fault auto insurance law in coverage disputes between Michigan no fault auto insurers and self-funded ERISA plans. The court, in this decision, permitted no-fault insurers to pursue claims against ERISA plans directly under state law, in order to force them to pay auto accident claims on a primary basis even if that result was inconsistent with or impaired the ERISA plans' provisions. This holding, however, was effectively overturned by this Court's 1990 decision in *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990), that the application of state law to self-funded ERISA plans is preempted. The death of *Northern Group Services* was confirmed one week after *FMC* was decided, when this Court entered its order in *Thorn Apple Valley, Inc.* v. *Auto Club Insurance Ass'n*, 498 U.S. 996 (1990), *vacating sub nom., Auto Club Insurance Ass'n* v. *Frederick & Herrud, Inc.*, 175 Mich. App. 412, 438 N.W.2d 320 (1989).

Two years later in 1992, the Sixth Circuit acknowledged the demise of *Northern Group Services*, and the clear preemption of state law in no-fault automobile insurance/ERISA plan controversies in *Health & Welfare Plans* and *Lectron Products*. It remanded both cases to the district court level to determine how "federal common law" would apply to the disputes. Although in both cases the Sixth Circuit suggested the possibility of apportioning liability, this was clearly not mandated.

The district court in the case at bar, in the meantime, became the first (and so far as we are aware only) fed-

eral court (post-*FMC*) actually to apply a pro rata apportionment remedy in a no-fault automobile insurance/ERISA plan dispute as a matter of "federal common law." In reversing the district court, the Sixth Circuit considered *Health & Welfare Plans* and *Lectron Products*, along with an intervening decision by the Michigan Supreme Court in *Auto Club Insurance Ass'n* v. *Frederick & Herrud, Inc.*, 443 Mich. 358, 505 N.W.2d 820 (1993), *cert. denied sub nom.*, *Auto Club Insurance Ass'n* v. *Pentwater Wire Products, Inc.*, 511 U.S. ___, 114 S. Ct. 1300 (1994),[5] and concluded that an apportionment of liability between a no-fault insurer and an ERISA plan would be inappropriate under "federal common law." Instead, the Court held that in view of the broad pre-emptive effect of ERISA, the terms of the ERISA plan should be enforced as written, and that the no-fault auto insurer must therefore be primarily responsible for paying the auto accident related medical expenses of its own insureds.

In the context of this developing case law, the Sixth Circuit's decision below has created no conflict or lack of uniformity within the Sixth Circuit. In refusing to grant *en banc* rehearing, the Sixth Circuit acknowledged as much.

Seventh Circuit

As have Michigan auto insurers in each of their two previous attempts to convince this Court to review the application of "federal common law" to Michigan no-fault auto insurance/ERISA plan coverage disputes, Auto Owners again urges that the Sixth Circuit's decision here conflicts with the Seventh Circuit's 1988 decision in *Winstead* v. *Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989). A review of developing ERISA

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[5] This was the same case that was vacated and remanded by this Court in 1990. *See* 498 U.S. 996 (1990).

case law in the Seventh Circuit, however, confirms that *Winstead* does not reflect (and for a number of years has not reflected) current law even in the Seventh Circuit.

Winstead involved a coverage dispute between a Michigan no-fault insurer and an Illinois based ERISA plan that happened to be litigated in the Seventh Circuit rather than the Sixth Circuit. Without having the benefit of this Court's decisions in *FMC Corp.* v. *Holliday*, 498 U.S. 52 (1990); *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989) and *Mertens* v. *Hewitt Associates*, 508 U.S. ___, 113 S. Ct. 2063 (1993), and without even directly addressing whether *Michigan law* is preempted by ERISA,[6] the Seventh Circuit panel in *Winstead* approved a "pro rata" division of liability, which it said was "not only in keeping with generally accepted notions derived from state common law . . . but [which] seems eminently fair and equitable." 855 F.2d at 434. The court did not say how this "solomonic" remedy was divined from either ERISA's text or its underlying policies, nor did it provide any other rationale for adopting it.

The holding in *Winstead* has not been followed by the Seventh Circuit in subsequent cases. There appear to be a number of reasons for this:

1. As previously indicated, *Winstead* preceded this Court's decisions in *FMC*, *Bruch* and *Mertens*, each of which significantly altered and clarified the legal landscape for adjudicating claims against ERISA plans. More recently, the Seventh Circuit has squarely refused to use "federal common law" to augment the specific remedial provisions of Section 502 of ERISA. *Buckley Dement, Inc.* v. *Travelers Plan Administrators of Ill., Inc.*, 39 F.3d at 790.

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6 *Northern Group Services* was then the prevailing law in the Sixth Circuit on the issue of preemption, but the Court in *Winstead* declined to adopt it, suggesting that "it is by no means clear that we would follow *Northern Group Services* should the question be presented." 855 F.2d at 435.

2. Subsequent to *Winstead*, the Seventh Circuit effectively repudiated the essential premise on which that case was decided, by recognizing that Congress had provided no basis under ERISA for "consolidated litigation when a plan subject to ERISA interlocks with coverage governed by state law." *Foster McGaw Hospital of Loyola University of Chicago* v. *Building Material Chauffeurs, Teamsters and Helpers Welfare Fund of Chicago, Local 786*, 925 F.2d 1023, 1025 (7th Cir. 1991), *cert. denied*, 502 U.S. ___, 112 S. Ct. 74 (1991). Having recognized that there is no basis for "consolidated litigation" to resolve coverage disputes between ERISA plans and state regulated coverages in the first place, it is hardly surprising that the Seventh Circuit has not revisited *Winstead's* "solomonic" apportionment of liability.

3. Additionally, the Seventh Circuit has held in recent decisions that in developing "federal common law" in ERISA cases, the courts must "effectuat[e] the policies underlying ERISA." *E.g.*, *Thomason* v. *Aetna Life Insurance Co.*, 9 F.3d 645, 647 (7th Cir. 1993). In this regard, it has also ruled that it is of no consequence that the enforcement of ERISA plans as written will "abrogate principles of state law." *Land* v. *Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Health and Welfare Fund*, 25 F.3d 509, 513 (7th Cir. 1994). Whatever its merits, *Winstead's* apportionment rule is a state law rule that cannot be square with any policies or principles emanating from ERISA.

In view of these developments, it is hardly surprising that *Winstead* has not been followed by the Seventh Circuit since its issuance.

Other Circuits

Auto Owners does not directly contend that the Sixth Circuit's decision below conflicts with the law in other circuits. In fact, it does not.

A dispute over coverage between two ERISA plans can, at least arguably, be litigated directly under Section 502(a)(3) of ERISA, as a claim by one plan "to enforce" its provisions against the other plan. *See Winstead* v. *J.C. Penney Co.*, 933 F.2d 576, 578-79 (7th Cir. 1991). Several circuits have attempted to formulate "federal common law" to resolve such ERISA plan disputes. But resolving coverage disputes between ERISA plans under ERISA is hardly comparable to inventing a cause of action for resolving a coverage dispute between an ERISA plan and an entity which is not covered by ERISA at all.

In 1985, the Third Circuit in *Northeast Department ILGWU Health & Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985), held in the context of a dispute between two ERISA plans that inclusion in a multi-employer ERISA plan by the plan's trustees of an "escape clause," whereby coverage under that plan would not apply if the beneficiary was covered elsewhere might constitute a breach of fiduciary duty under ERISA. More recently, the Third Circuit severely limited its holding in *Northeast* to the adoption of an "escape clause" by the trustees of a multi-employer benefit plan. *Nazay* v. *Miller*, 949 F.2d 1323, (3d Cir. 1991). The Third Circuit having limited its holding in *Northeast* to the narrow facts of that case, facts which are not remotely applicable here, there is no basis for suggesting that the Third Circuit would today hold TAV's coordination of benefits provision "unenforceable" or a breach of fiduciary duty.

The Ninth Circuit, in *PM Group Life Insurance Co.* v. *Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir.

1992), borrowed the so-called "birthday rule" from state insurance law to resolve a coverage dispute between two ERISA plans. This Court recently declined to consider *that* issue. *See Inter Valley Health Plan* v. *Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 19 Cal. Rptr. 2d 782 (1993), *cert. denied*, ___ U.S. ___, 114 S. Ct. 881 (1994). Having determined that there is no need to consider the application of federal common law to coverage disputes between ERISA plans, concerning which an ERISA cause of action at least arguably exists under Section 502, it is problematic how the Court could find persuasive Petitioner's request that it decide the application of "federal common law" to a dispute between an ERISA plan and an insurance company, regarding which no cause of action under Section 502 exists at all.

State Court Decisions

Auto Owners ignores in its petition a decision by Michigan's highest court which is in full accord with the Sixth Circuit's decision below. In *Auto Club Insurance Ass'n.* v. *Frederick & Herrud, Inc.*, 443 Mich. 358, 505 N.W.2d 820 (1993), the Michigan Supreme Court unanimously held that in a coverage dispute between a no-fault insurance carrier and an ERISA plan the coordination of benefits provision in the ERISA plan "must be given its clear meaning without the creation of any artificial conflict [with the auto carrier's policy] based upon [MICH. COMP. LAWS § 500.3109a]." *Id.* At 387, 505 N.W.2d at 833. Thus, the "federal common law" rule applied in such disputes by the Michigan courts is identical to the rule of law announced by the Sixth Circuit below. Significantly, the Court declined to review *Frederick & Herrud* approximately one year ago. *Auto Club Insurance Ass'n.* v. *Pentwater Wire Products, Inc.*, 511 U.S. ___, 114 S. Ct. 1300 (1994). The Sixth Circuit's endorse-

ment of the position taken by Michigan's highest court surely does not present a more compelling case for review.

Other state decisions which Petitioner claims are in conflict with the Sixth Circuit's decision below do not in fact even address the application of "federal common law" to coverage disputes between ERISA plans and coverages governed by state law, much less provide conflicting rules of law. *Inter Valley Health Plan*, 16 Cal. App. 4th at 60, 19 Cal. Reptr. 2d at 782 (1993), *cert. denied*, ___ U.S. ___, 114 S. Ct. 881 (1994), involved a coverage dispute between two ERISA plans, again a very different situation from the one at bar, concerning which a cause of action under Section 502 of ERISA does not even arguably exist. In *Blue Cross and Blue Shield of Kansas, Inc.* v. *Riverside Hospital*, 237 Kan. 829, 703 P.2d 1384 (1985), an insurance company providing health benefits to employees of a governmental employer (which was exempt from coverage under ERISA) was permitted to sue an ERISA plan under state law theories of "contribution and indemnity." The Kansas court's rejection of ERISA preemption in this 1985 decision, however, cannot be reconciled with this Court's 1990 decision in *FMC* holding that the application of state law to ERISA plans is preempted.

So far as we are aware, no state or federal court has adopted a "federal common law" rule that conflicts with the Sixth Circuit's decision below.

III.

THE DECISION BELOW ADVANCES RATHER THAN IMPAIRS THE POLICIES UNDERLYING ERISA.

Turning ERISA and its underlying policies completely upside down, Auto Owners contends that Congress'

mandate in Section 514 of ERISA that ERISA plans be immune from obligations imposed by state law should be ignored, and a remedy in favor of no-fault insurance companies against ERISA plans should be judicially created under the guise of developing "federal common law." Aside from incessantly chanting that it is somehow unfair or unjust to force auto insurers in Michigan to pay the medical claims of their own insureds, which is anything but self-evident, Auto Owners articulates no policy emanating from ERISA that would be furthered by adopting a "federal common law" rule which forces ERISA plans to reimburse no-fault auto insurers for medical claims incurred by plan beneficiaries in contravention of plan language expressly providing otherwise.

There is nothing "blurry" or otherwise faulty in the Sixth Circuit's conclusion that the preemptive effect of ERISA has created an unlevel "playing field" which immunizes ERISA plans from claims that the plans have "expressly disavowed." Congress broadly preempted state laws that relate to ERISA plans. *See* 29 U.S.C. § 1144(a) (1985). Auto Owners' no-fault auto insurance policy contains a coordination of benefits clause *because* of the preempted state law that mandated it. *See* MICH. COMP. LAWS § 500.3109a. If the clause is not therefore *void*, since the law that mandated it is void, the clause is certainly *unenforceable* against ERISA plans in the context of lawsuits which seek to force the plans to provide coverage that the plans' fiduciaries have denied.

The interests of participants and beneficiaries of ERISA plans, which ERISA is clearly intended to protect, *see* 29 U.S.C. § 1001(b), would not be advanced by a "federal common law" rule allowing auto insurance carriers to force ERISA plans to pay claims they have expressly disclaimed. Indeed, plan participants and beneficiaries,

such as Chris Shattuck, would not benefit one bit from such a result. After all, Mr. Shattuck's medical expenses were paid by Auto Owners in full, and Auto Owners only brought this litigation in an attempt to force TAV to indemnify *it*, not Mr. Shattuck. *See generally Physicians HealthChoice* v. *Automotive Employee Benefit Trust*, 988 F.2d 53 (8th Cir. 1993). Auto Owners' sheer speculation that under the Sixth Circuit's decision below ERISA plan beneficiaries will somehow be deprived of the right to purchase "less expensive" no-fault automobile insurance in Michigan, an outcome which is also far from obvious, cannot be said fairly to invoke any policy considerations emanating from ERISA, much less serve as a justification for creating "federal common law" out of whole cloth.

CONCLUSION

For these reasons, the petition for writ of certiorari should be denied.

Respectfully submitted,

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Dated: January 19, 1995

APPENDIX TO BRIEF IN OPPOSITION

-STATUTES INVOLVED-

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SECTION 502 OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED, 29 U.S.C. § 1132

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l) of this section.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if —

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $ 1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs, awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in

favor of the plan is awarded, the court shall award the plan —

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of —

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may

not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 2975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final

order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of —

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) —

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (1)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that —

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

SECTION 514 OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED, 29 U.S.C. § 1144

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance

contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section —

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in

effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section —

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt

from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State, qualified medical child support orders (within the meaning of section 1169 (a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent enforced by qualified medical child support orders.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

SECTION 3190a OF MICHIGAN'S NO-FAULT AUTO INSURANCE LAW; MICH. COMP. LAWS §500.3109a

Sec. 3109a. An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

MOTION FILED
JAN 26 1995

No. 94-1137

In The
Supreme Court of the United States
October Term, 1994

AUTO-OWNERS INSURANCE COMPANY,
Petitioner,
-vs-
THORN APPLE VALLEY, INC.,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

MOTION
OF MICHIGAN ASSOCIATION OF INSURANCE COMPANIES
FOR LEAVE TO FILE BRIEF *AMICUS CURIÆ*
IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI
~AND~
BRIEF *AMICUS CURIÆ*, WITH APPENDICES

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MOTION

OF MICHIGAN ASSOCIATION OF INSURANCE COMPANIES
FOR LEAVE TO FILE BRIEF *AMICUS CURIÆ*
IN SUPPORT OF PETITIONER, AUTO OWNERS INSURANCE COMPANY

Michigan Association of Insurance Companies (MAIC) moves for leave to file the attached brief *Amicus Curiæ* in this case. The consent of the attorney for Petitioner has been obtained. The consent of the attorney for the Respondent was requested, but refused.

Amicus Curiæ, Michigan Association of Insurance Companies, is a non-profit public affairs trade association of approximately 50 property-casualty insurance companies, 30 of which are domestic or Michigan-based companies. MAIC's members insure over 80% of the private passenger vehicles registered in the State of Michigan. One of the purposes of MAIC is to analyze and present its opinions concerning court decisions which affect the insurance industry and public.

MAIC's interest in this case arises from the fact that the Sixth Circuit's decision in the instant case invalidates coordination of benefits (COB) clauses in all no-

fault automobile insurance policies issued by its members to persons who are participants or beneficiaries of ERISA plans.

In the instant case, the Sixth Circuit justified its holding on the ground that it would protect the interests of ERISA participants and beneficiaries. (Petition for Writ of Certiorari, 10a-11a). However, no apparent consideration was given to the impact of that decision on the no-fault insurance premiums paid by ERISA participants and beneficiaries, who will no longer be permitted to purchase coordinated no-fault coverage. Neither party is in a position to address that matter, because the record does not contain any of the data necessary to do so. The brief which *Amicus Curiæ* seeks leave to file provides such data as well as an analysis of the financial impact the instant case will have on those intended to be protected by the ERISA.

Respectfully submitted,

By: _____

/s/ JAMES G. GROSS
Counsel of Record
for Amicus Curiæ

444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200

Dated: January 26, 1995

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BRIEF *AMICUS CURIÆ*
IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

INTEREST OF *AMICUS CURIÆ*, MICHIGAN ASSOCIATION OF INSURANCE COMPANIES

Amicus Curiæ, Michigan Association of Insurance Companies (MAIC), is a non-profit public affairs trade association of approximately 50 property-casualty insurance companies, 30 of which are domestic or Michigan-based companies. MAIC's members insure over 80% of the private passenger vehicles registered in the State of Michigan. One of the purposes of MAIC is to analyze and present its opinions concerning court decisions which affect the insurance industry and public.

The Sixth Circuit decision in the instant case invalidates all coordination of benefits (COB) clauses in all no-fault automobile insurance policies issued by MAIC's members to all participants or beneficiaries of ERISA health plans. The result in the short term is a loss to the insurers because the premiums calculated on policies affected by that decision did not reflect the insurers' actual exposures for payment of medical bene-

fits. However, the long term result will be that coordinated no-fault coverage will not be available in Michigan to ERISA participants or beneficiaries. That will result in a substantial increase in the premiums paid by those persons for no-fault insurance. Both the short-term impact on its members and the long-term impact on its members' insureds are matters in which MAIC has a substantial interest.

ARGUMENT

THE SIXTH CIRCUIT'S DECISION IN THE INSTANT CASE WILL RESULT IN AN AGGREGATE ANNUAL INCREASE OF APPROXIMATELY $165 MILLION IN AUTOMOBILE INSURANCE PREMIUMS PAID BY MICHIGAN PARTICIPANTS AND BENEFICIARIES OF ERISA PLANS.

As the Sixth Circuit pointed out in the instant case, the fundamental purpose of the ERISA is to protect the interests of employee benefit plan participants and beneficiaries. (Petition for Writ of Certiorari, 10a). Ironically, that court's decision will result in a substantial increase in the premiums paid for no-fault automobile insurance by Michigan participants in ERISA plans, without any apparent net benefit to those participants.

In 1991,[1] 83% of full-time employees of medium to large private establishments[2] in this country were participants in employer-provided medical care plans. Current Labor Statistics, U.S. Bureau of Labor Statistics, Monthly Labor Review (December 1994), p 95. In

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1 **The 1991 figures are the most current available from the U.S. Bureau of Labor Statistics.**

2 **That category includes all private sector establishments employing 100 workers or more in all industries. (Current Labor Statistics, U.S. Bureau of Labor Statistics, Monthly Labor Review [December 1994], p 95 n 1).**

1993,[3] the State of Michigan had an average annual employment of 4,374,000. Source: Michigan Employment Security Commission, Information and Reports Section. Assuming that Michigan workers participate in ERISA plans at the national rate,[4] 3,630,420 Michigan employees are ERISA plan participants.

In 1993, 5,488,966 policies of Michigan no-fault automobile insurance were issued. Source: Michigan Catastrophic Claims Association (see Appendix 2). Of those, approximately 75%, or 4,116,725 policies, provided coordinated medical coverage. (Appendix 2). The estimated total premium reduction for the purchase of coordinated policies in 1993 was between $200 million and $300 million. (*Id.*).

The Michigan No-Fault Act requires only that insurers offer the option of coordinating no-fault insurance with other health and accident coverage which is available to the insured if he is involved in an automobile accident.

> "An insurer providing personal protection insurance benefits shall offer, at a [*sic*] appropriately reduced premium rates, deductibles and exclusions *reasonably related to other health and accident coverage on the insured.*"

MCL 500.3109a; MSA 24.1309(1) (emphasis added).

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[3] In making the calculations set forth in the text, *Amicus Curiæ* opted to use the most current statistics available. Although using 1991 ERISA data with 1993 Michigan employment figures will necessarily result in some inaccuracy, *Amicus Curiæ* opted to do so in order to provide the best estimate of the *current* situation, rather than a more accurate calculation of the situation as it existed three years ago. Also, the text approach will require the substitution of only one figure to correct the inaccuracies when the 1993 ERISA figures become available from the U.S. Bureau of Labor Statistics.

[4] The Pension and Welfare Benefits Administration of the U.S. Department of Labor does not have a breakdown of the number of Michigan employees who are participants of ERISA health plans.

It is self-evident that if the Sixth Circuit's decision is allowed to stand, a no-fault insured whose "other health and accident coverage" is an ERISA plan will not be able to purchase coordinated no-fault medical coverage. (The no-fault premium reduction "reasonably related" to the existence of an ERISA plan would be zero.) As a result, assuming that they currently purchase coordinated no-fault coverage at the same rate as the Michigan motoring public in general, Michigan ERISA plan participants will pay approximately $165 million per year in increased auto insurance premiums.

Nor does it follow that reversal of the Sixth Circuit's decision would result in those costs being simply passed back to Michigan ERISA participants in the form of increased employee contributions to plans or a reduction in benefits provided by those plans.

In the first place, the increase in costs to ERISA plans would not be equal to the cost of providing Michigan no-fault benefits. Michigan is the only state in this country which provides full lifetime medical benefits to victims of automobile accidents. Very few, if any, ERISA plans provide such extensive coverage. Consequently, the increased cost to a ERISA plan would only be that of affording the far more limited plan coverage to victims of automobile accidents. Michigan no-fault insurers would still pay the difference between that limited coverage and the total medical expenses incurred by the insured.

Second, any cost increase that would result would not necessarily be borne solely by Michigan ERISA participants. By hypothesis, COB or exclusion clauses rendering no-fault insurers primarily or exclusively responsible for medical benefits will affect only those

plans in states with no-fault automobile insurance systems.[5] In other states, such clauses are nullities.

However, the general or prevalent underwriting predicate of ERISA plans of firms doing business in other states as well as Michigan is unknown. If, as seems likely, such plans calculate their projected costs on the basis of their entire (multi-state) exposure for auto accident-related medical expenses, then the cost of requiring coverage for Michigan motor vehicle accidents would be spread over a premium base larger than one consisting only of Michigan insureds. The result is that the increased cost per Michigan ERISA participant would be diluted accordingly.

Consequently, to the extent that the foregoing is true, by requiring Michigan plan participants to bear the entire cost increase engendered by a reversal of the Sixth Circuit's decision in the instant case, employers would be imposing a disproportionate share of the cost on them. It should not be assumed that employers would act in such an arbitrary manner.

In short, it does not necessarily follow that reversing the Sixth Circuit's decision in the instant case will result in imposing on Michigan ERISA plan participants an additional $165 million in increased ERISA costs. It will, however, increase their no-fault insurance premiums by that amount. Thus, the net result of the Sixth Circuit's decision is a palpable and demonstrable economic

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[5] Although it is outside the scope of its interest in this case, *Amicus Curiæ* points out that in states with no-fault systems which provide very limited benefits, giving full effect to escape clauses such as Petitioner's will result in participants and beneficiaries receiving *less* than what the plan provides. That result is directly contrary to the Congressional intent of the ERISA. *Northeast Department ILGWU Health & Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 M. 2d 147 (3rd Cir. 1985).

detriment to the very persons whom the ERISA was intended to protect.

Finally, in any event, even if we assume that the increased cost to ERISA plans would equal the amount of no-fault premium increases, *and* that they would all be passed back to Michigan ERISA plan participants, the net result would be an economic nullity. Participants would neither benefit nor suffer. And that would leave the Sixth Circuit's decision bereft of any basis in the Congressional intent.

CONCLUSION

The Sixth Circuit's decision in the instant case will undeniably and substantially increase the automobile insurance premiums of ERISA plan participants and beneficiaries. Moreover, it will do so without any demonstrable net benefit to them. That being so, said decision is *contrary* to the Congressional intent in enacting the ERISA. This Court should grant certiorari for the purpose of reversing the decision of the Sixth Circuit in the instant case.

Respectfully submitted,

By: /s/ JAMES G. GROSS
Counsel of Record
for Amicus Curiæ

444 Penobscot Building
Detroit, Michigan 48226
(313) 963-8200

Dated: January 26, 1995

APPENDICES TO BRIEF *AMICUS CURIÆ*

• • •

APPENDIX 1

11/19/94 MEMORANDUM FROM TERRY BUCKLES TO JAMES GROSS

MAIC
MICHIGAN ASSOCIATION OF INSURANCE COMPANIES
404 Kalamazoo Plaza, Suite 100 — Lansing, Michigan 48933
517/482-1643 — Fax 517/482-0031

To: Jim Gross — FAX 313-964-6577

Re: Data survey for *Auto-Owners* v *Thorn Apple Valley*

From: Terry Buckles

Below is a detailed description of the data we plan to collect for your use. Please review and advise me by November 18 if this will not meet your needs. If I don't hear from you, we will proceed.

It is our intent, by the way, to seek participation of AAA, Auto-Owners, Citizens, State Farm and Allstate. Collectively, they control about 74% of the private passenger auto insurance market in Michigan.

Data to be requested by private passenger auto coverage in Michigan during calendar years 1990, 1991, 1992, and 1993

1. Number of vehicles insured
2. Number of insured vehicles with *coordinated medical benefits* PIP coverage
3. Direct written premium for the *medical benefits* portion of PIP coverage (excluding premium written for

replacement services, wage loss, funeral, etc., coverage)

4. Total premium reduction given to insureds for purchasing a policy with coordinated *medical benefits* PIP coverage

5. Total amount of claims paid and incurred for the *medical benefits* portion of PIP coverage (excluding claims paid under replacement services, wage loss, funeral, etc., coverage)

APPENDIX 2

1/13/95 LETTER FROM TERRY BUCKLES TO JAMES GROSS

MAIC
MICHIGAN ASSOCIATION OF INSURANCE COMPANIES
404 Kalamazoo Plaza, Suite 100 — Lansing, Michigan 48933
517/482-1643 — Fax 517/482-0031

James G. Gross
Gross, Nemeth & Silverman, P.L.C.
444 Penobscot Building
Detroit, MI 48226-4018

January 13, 1995

Dear Jim:

Here is the information you requested for *Auto-Owners* v *Thorn Apple Valley*. It is not as precise or comprehensive as I had hoped. Not all of the insurers were able to provide the numbers as I had requested them; but I hope this will be satisfactory for your purposes.

Responses in items 2, 3 and 4 below are estimates developed from data provided by four insurer groups which write about 67 percent of the private passenger no-fault Personal Injury Protection (PIP) coverage for Michigan residents:

1. Private passenger (not including motorcycles) earned vehicle year exposures under Michigan no-fault in 1993 were 5,488,966. Source: Michigan Catastrophic Claims Association.

2. Estimated number of such exposures subject to coordination of PIP benefits during 1993: 4,116,724 or 75 percent.

3. Estimated dollar amount of premium reduction received by Michigan private passenger insureds for

the purchase of coordinated PIP coverage in 1993: $200 to $300 million.

4. Estimated dollar amount of paid (but not incurred) *medical* claims under Michigan private passenger PIP coverage during 1993: approximately $400 million.

Bill VonSeggern, Chief Actuary of AAA Michigan, has offered his assistance in drafting technical aspects of the brief. If you are interested, you can reach him at 313-462-7286.

Cordially,

Terry N. Buckles
President